

Risk Matters, Creating The New Network

Lehigh Valley Health Network

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Published In/Presented At

(2016). Risk Matters, Creating The New Network... LVHN Scholarly Works.

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RISK MATTERS



CREATING THE NEW NETWORK

How Lehigh Valley Health Network is rethinking relationships to progress along the risk continuum

BUNDLED PAYMENT LESSONS

Takeaways for your broader value-based strategy

SIX KEY TIPS

How to contract with an employer

PROVIDER-SPONSORED HEALTH PLANS

How to evaluate the business case

NETWORK EVOLUTION

Thinking beyond primary care practitioners

PLUS: The secret sauce of the next health care



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partnership success

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Choose the right providers to drive the right results

Each connection makes you stronger

A meeting, a conversation are just the beginning. The growth, the value and the evolution can be what follow. The idea of partnership between internal and external systems, payers and providers as well as major corporations and small community groups, provide the ability to better serve the patient population while lowering cost. And this can all happen within value-based care. However, you will need one thing to hold it all together: Trust.

Trust between stakeholders is the primary driver of change. No matter how good a model or solution you may build, unless the stakeholders jointly work together to embrace the change, the transformational journey will not be successful. The catalyst for change is built on the trust between leaders and frontline workers. It has the potential to grow increased value for both parties and oftentimes additional parties that they are connected to.

Any partnership construct for a value-based care journey should require that providers partner with one another for the interest of the patient. There are various successful examples of governance models, partnership structures and decision rights frameworks that can be implemented to foster the desired partnership.

Collaboration is the other key success factor. Collaboration between providers, between payers and providers and with employers or health care sponsors requires us to break the silos and attain a common ground. It requires aligning incentives, and along with it a discipline to ensure that the various entities and stakeholders work together for a common goal—to improve the effectiveness and efficiency of care.

This value in trust—the partnership it provides and the growth it creates—can often be seen as the one immeasurable element of creating the highest quality care. This issue of *RISKMATTERS* will explore that idea of creating the new network of health care through trust and partnerships. We hope you enjoy the contents of this insightful edition.



AN OVERLOOK RELATIONSHIP:

EPISODIC BUNDLES AND
MANAGING TOTAL COST OF CARE



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How lessons learned from bundled payment management can inform your organization's broader value-based strategy

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The Centers for Medicare and Medicaid Services (CMS) continues to invest in accountable care organizations (ACOs) with the Medicare Shared Savings Program. Commercial payers have also taken an interest in similar programs that attempt to better manage the total cost of care.

ACOs are not the CMS's only focus. CMS is placing a renewed emphasis on managing episodic payments. In 2013, it launched the Bundled Payments for Care Improvement (BPCI) initiative, a voluntary program that pays providers for a bundle of services associated with an episode of care rather than for each individual service.¹

In April 2016, CMS launched its Comprehensive Care for Joint Replacement (CJR) model, which requires hospitals in 67 metropolitan areas to bundle payments for hip and joint replacements. Each year, actual provider charges will be compared to target prices. Providers with lower costs will receive an additional payment from CMS, while those with higher costs will owe CMS the difference between the target price and the actual charge.²

Bundled payment initiatives have been around for several years in Medicare, but commercial payers have been slow to adopt bundled payment programs. So why is CMS placing so much emphasis on them? And how do they fit into the broader fabric of value-based care?

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BUNDLED PAYMENTS ARE DISTINGUISHED FROM OTHER VALUE-BASED CONTRACTS

“These CMS programs present a really interesting dynamic,” said Jeremiah Reuter, director of risk advisory consulting at Optum. “As much as we think that the end game is managing the total cost of care for providers, CMS is carving out a portion of that with episodic initiatives.”

Episodic management is a subset of total-cost-of-care management, but it represents a large subset in financial terms and there is a large variation in costs associated with similar episodes across providers. For example, a large portion of savings for a Medicare ACO comes from managing post-acute care. In the case of hip and knee replacements, Medicare pays anywhere from

\$16,500 to \$33,000 per care episode.³ By incentivizing efficiency and care coordination in the area of lower extremity joint replacement surgeries, Medicare is hoping to improve quality and decrease costs.

Contrast that with payment models focused on controlling total cost of care. While bundled payments are in place to incentivize better care for a patient’s episode of care, the primary goal for total-cost-of-care programs is to prevent such episodes altogether within their population.

Bundling payments does take more administrative effort on the part of both payers and providers, and sometimes the additional administrative expense does not offset the savings from a reduction in medical expense. Joint replacements are a high-

CRITICAL CAPABILITIES

One thing that is not likely to change is Medicare’s focus on driving down costs and shifting the financial risk from payers to providers, and bundled payments look to be a fixture in Medicare’s cost-control efforts.

To that end, Schneider and Reuter recommend health care providers proactively prepare to participate by

focusing on the following:

RISK STRATEGY.

Organizations that have an enterprise risk strategy can make the best decisions about bundled payment participation. Providers need to be able to assess the risk of these programs. Reuter explained, “Every program is not created equal, and there is risk and opportunity within each program. So you have to take a look at your organization and understand whether it makes sense to be involved.”

MULTIDISCIPLINARY GOVERNANCE.

Bundled payments cut across care delivery, IT and data management, financial and risk management, care management and patient engagement. Having executives from these areas within an organization on board is critical.

RISK ASSESSMENT/ANALYTICS.

Data and analytics are basic tools of risk assessment. They can help organizations not only assess overall risk associated with participation in bundled payments, but can also assist in categorizing and benchmarking their results.

volume procedure for Medicare and CMS's goal of greater efficiency, if successful, will impact the health and cost for a large portion of the population.

On the other hand, commercial payers are currently more focused on total-cost-of-care programs because there is more opportunity for savings within the populations they serve.

"The industry's experience with bundled payments has taught us that orthopedics, cardiac surgery and organ transplants are the areas where episodic management can make a big difference," said Andrew Schneider, vice president of health management consulting for Optum. There are other areas of interest and potential,

but they aren't as widespread, especially in commercially insured populations. The episodes that are commonly bundled typically do not have a high prevalence among commercially insured populations. As a result, investments are made in programs that impact a greater portion of the population than bundled payment programs.

Bundled payments are not out of the realm of possibility for commercial payers, though, and they are looking to gauge the success of Medicare's new programs.

"Right now, there is not a lot of interest in bundled payments from commercial payers, but if BPCI or CJR is wildly successful, that could change things," Schneider said.

ARE NEEDED TO SUCCEED IN BUNDLED PAYMENT ARRANGEMENTS

PROVIDER ENGAGEMENT.

Before engaging in a bundled payment program, organizations should identify physician champions to participate who are cognizant of quality and efficiency. Providers also need a process in place to engage with doctors who need improvement. Care architecture, which includes care delivery and all the care management services wrapped around care delivery, is key.

POST-ACUTE STRATEGY.

Much of the variation in cost—and, therefore, opportunity—occurs after the patients leave the hospital. "We have seen providers that use less post-acute resources achieve equal or better quality outcomes than providers that use more, simply because they have a strategy in place to discharge patients to the appropriate level of care with a high-performing provider," said Schneider.

DATA-DRIVEN NETWORK ANALYSES.

Identifying high performing post-acute care providers in which the bundle owners or ACO participants can partner with to help manage the episode once the patient has been discharged from the inpatient setting often includes identifying providers that specialize in particular service lines (cardiology, neurology, pulmonary, etc.). For patients living in assisted living facilities (ALFs), data-driven analyses can be completed to identify well-performing ALFs, which oftentimes are those that have relationships with post-acute care providers.

WITH CJR LOOMING, WHAT SHOULD PROVIDERS UNPREPARED FOR RISK DO TO PREPARE?

Many executives might be tempted to buy some sort of technology that facilitates bundled payments and call themselves ready. Those who do so would be skipping an important step: strategy. Strategic conversations should assess goals for participation, competitive advantages and vulnerabilities, and make a true assessment of the risks involved, especially the financial risks.

“In this new world, providers are no longer able to budget based on the number of procedures or services they’re doing,” Reuter said. “Now, they need to know what their

likely financial position will be after managing a population or after managing episodes through value-based contracts.”

The value-based landscape is motivating payers and providers to invent new methods (or in many cases, reinvent old methods) for payment and care delivery. And we are likely seeing only the tip of the iceberg.

“We have a health care crisis in the United States, and across the world, and we are addressing the crisis through innovation,” Reuter said.

Reuter sees four distinct opportunities for optimizing performance under bundled payments.

- 1. Measuring value** (outcomes and cost) across entire episodes. The measurement should be applied to specific physicians to identify and measure performance, and used in steering patient volume to the highest performing specialists.
- 2. Care delivery optimization.** Use of standardized, evidence-based protocols can reduce length of stay, complications and patient recovery time.
- 3. Robust transition management** to follow and coordinate care post-discharge. Assemble a multidisciplinary team that handles the diverse issues patients may have post-discharge, including pharmacy management, community resource engagement and care plan adherence.
- 4. Steering patients to high-quality, post-acute care providers.** Post-acute care from a hospital's preferred network of SNFs, home health agencies and community-based resources can keep the patient healthier by mitigating readmission risk and minimizing post-discharge complications.

“Bundle payment models are often largely led by specialists, whereas total cost of care is optimally driven from a primary care led model, such as a Patient Centered Medical Home (PCMH). There is a debate on which model will ultimately prevail, but we believe that both of these value-based care models will continue to proliferate and coexist.”

“There is a debate will ultimately prevail, but of these value-based care to proliferate and coexist.”

¹ <https://innovation.cms.gov/initiatives/bundled-payments>

² <https://innovation.cms.gov/initiatives/cjr>

MANDATORY BUNDLED PAYMENT PROGRAMS WILL HELP ORGANIZATIONS PREPARE FOR FUTURE VALUE-BASED CONTRACTING

Organizations that approach bundled payments, as Reuter and Schneider outline, can transfer the strategies and capabilities to better position the organization for future risk. Positive experiences with bundled payments shows how risk related to total cost of care can turn into opportunity.

“Some providers have used bundled payments as a stepping stone for taking on broader risk,” Schneider said. “They’re using programs like the Medicare Bundled Payment Care Initiative to build risk-bearing capabilities. Bundled payments enable efficient management of an episode. So while it’s a subset of total cost of care, some of the capabilities are similar to those you need as you take on more risk for a population.”

In developing a robust approach for bundled payments leveraging actuaries, clinicians, network managers, analysts and other strategic advisors, organizations participating in programs such as BCPI and CJR will be set up to manage both bundled payment and other value-based models in the following areas:

- **Maximize** performance across risk and quality scores for their patient populations
- **Design** and operationalize population health programs to improve patient incomes
- **Manage** the financial and clinical risk factors for their patient populations
- **Help** align incentives and operations for providers with emergent value-based payment models

Executive buy-in and high-level leadership in bundled payments also gives leaders invaluable experience on which to rely when population-based prospects come calling. Using transparent data and analytics to improve care quality within bundles can help the organization’s leaders put data to best use and help employed and affiliated physicians trust the data and boost efforts to provide evidence-based care.

Providers of common total joint replacements in the 67 metropolitan areas where CJR is focused have no choice but to participate in bundled payments. While value-based care has taken a foothold from coast-to-coast, there are a number of markets where it has not emerged, and many organizations in these markets will have no choice but to begin managing risk. It will be a rude awakening for some, but it is one that can benefit an organization as health care continues to transition to value-based models.



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³ <http://healthaffairs.org/blog/2015/08/06/the-payment-reform-landscape-why-medicare-hip-and-knee-replacement-payment-model-may-not-be-the-answer-for-other-payers-and-purchasers/>



**DIRECT CO
WITH THEM**



INDUSTRY CONVERSATIONS

Optum risk and quality experts recommend this article for its high-value content surrounding value-based business models.

IN THE SPOTLIGHT: DIRECT CONTRACTING EMPLOYERS

Hospitals find alternatives to direct contracting

An increasing amount of hospitals and health systems are directly contracting with large employers to serve consumers, but pulling together direct-contracted arrangements with large, sophisticated employers can be difficult, experts say. So, what are those health systems to do if they can't assemble all the required pieces of a network, or find the sizable, concentrated employer willing to sign a contract?

Because employers are fed up with skyrocketing costs and the slow march away from fee-for-service medicine, it's important that a local health system demonstrate value to its potential customers, says Brian Marcotte, president and CEO of the National Business Group on Health. Otherwise, employers will craft new health plans that incent workers to go elsewhere.

The NBGH is now working to understand what exactly that value looks like, and is putting together a group of employers, payers and health systems to craft some recommendations. Demonstrating that value proposition is a good first step, whatever the circumstances in a hospital's service area.

"Even if you are not direct contracting, if you can demonstrate value and that you are better than the market, then employers can use plan design incentives to encourage employees to access care through those better delivery systems," Marcotte says. "I think that's the opportunity."

Some, such as Aurora Health Care in southeastern Wisconsin, have formed relationships with payers to sell ACO products to purchasers across the state. The system already has done so with about 275 employers, representing about 22,000 lives, enticing them with the opportunity to reduce costs by 10 percent in the first year. Scott Austin, senior vice president of commercial growth, says it was important to have the expertise of an insurer to analyze claims data, rather than trying to do it alone. Such arrangements need to be more than "just a grab for bodies to fill beds. It has to be that you are committed to lower costs for employers in your market."

SIX 6 TIPS

By Marty Stempniak.

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Craig Enge, chief operating and administration officer of Swedish-Providence, offers a few things he learned during the first year of working directly with aerospace giant Boeing to provide better care to its employees in Seattle.

A handful of health care systems are partnering with large corporations to better tailor care for their employees. In our feature on the subject, we discuss how hospitals and health systems are directly contracting with large employers to serve consumers in the same vein as Uber and Amazon.

1



ENGAGE EARLY

"Listen to what each group wants and needs from the network and what they can bring to it. Quite often, the value propositions of these organizations or the perception is not aligned right away, so you need time to be able to sit at a table together, listen to each other and come to common solutions. Additionally, when you start talking about direct-to-employer networks, it's very different from commercial or Medicare in that you are responsible for network adequacy. You need to identify who those people are in your network, and having access to somebody from a health plan that has done this before is extremely helpful."

2



DATA NEEDS

"I would start the data process as soon as possible and look for security clearances, look for the software you're going to use, and proactively start hiring data managers and analysts."

Other hospitals, meanwhile, are directly contracting with employers for a few select high-cost procedures. On the West Coast, for instance, the Pacific Business Group on Health has initiated what it calls the Employers Centers for Excellence Network, hoping to control costs on knee- and hip-replacement surgeries, Leavitt Partners notes in a recent report. Some 1.5 million employees and their dependents are able to access procedures at one of four health systems within the coalition. Travel and lodging costs are covered by the employer for visiting those centers, and the employees don't have to pay a deductible or co-insurance. The employer makes up for those investments with a discounted, fixed rate for every such surgery.

Craig Enge, chief operating and administration officer of the Swedish-Providence Health Alliance, hopes that as health networks continue to build up data and lessons learned, the industry eventually can perform similar work with much smaller groups of employees. Whatever the situation in your market, however, he says it's time to stop waiting.

"Just go," Enge says. "The learning you gain along the way, you will never be able to get sitting and waiting for that opportunity. I just tell people, 'Jump in.' "

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By Marty Stempniak.

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FOR CONTRACTING DIRECTLY WITH AN EMPLOYER

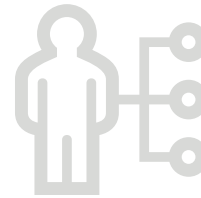




EXPAND

THE
CARE PROVIDER
NETWORK

ING



BECOMING MORE PATIENT-CENTERED IN YOUR VALUE-BASED TRANSITION

Health care has always been about the patient. Doctors and hospitals focus on curing ills. Ancillary providers like pharmacists and other therapists step in to help to get patients back to full health. And mental health providers such as psychiatrists and psychologists are ready to jump in when called upon. All want what's best for the individual, but traditionally coordinate services independent of one another.

That model works under fee-for-service, where providers are reimbursed for the number of patients they see or the volume of tests they order. But as value-based care takes hold, providers must place an even greater emphasis on outcomes and costs. The challenge is to continuously improve value by improving outcomes and lowering costs. In practice, this means focusing on prevention and keeping people healthy. When patients have to be hospitalized the focus is on quality and safety and transition to the next level of care as soon as possible.

One model that's showing promise is the development of patient-centered networks that bring together providers from all parts of the care continuum.

"The fundamental building block for such an advanced delivery system is to have a multidisciplinary team providing primary care that includes other functions, such as behavioral health and social services," said Dr. Michael Goran, physician lead, value-based care for Optum's consulting practice.

"Most health plans still have mental and behavioral health networks that are independent from their medical networks," he said. "The new trend is to make sure behavioral health is fully integrated, particularly into primary care, because a good part of the primary care practice is dealing with emotional and behavioral issues."

The key to patient-centered networks is to include all care disciplines and treat each individual in a coordinated and holistic manner. But that's easier said than done, Goran added. "Integration is not simple."



BARRIERS TO PATIENT-CENTERED NETWORKS

Building integrated provider networks can be difficult, especially when it comes to connecting disparate specialties like primary care and behavioral health under one umbrella. In some markets, there aren't enough behavioral and mental health specialists to cover all the cases a doctor's office or ED may see.

"Trying to find the right behavioral providers and get them working closely with your primary care network is a real challenge," Goran said. "There's no one way to do it because it's going to depend on who's available in your market."

The lack of behavioral and mental health specialists is a nationwide problem. For the 50 states and District of Columbia, there are only enough providers to cover 52 percent of the overall need. Rhode Island is the only state with 100 percent coverage, while South Dakota ranks last at 15 percent.¹

That shallow pool of resources can have a big financial impact. Care for behavioral and mental health patients cost hospitals approximately \$38.5 billion in 2014, an increase of nearly 90 percent from \$20.3 billion in 2003.² A portion of those costs come from patients with chronic diseases associated with depression. A Centers for Disease Control study showed that 145 million Americans were living with a chronic condition in 2009, nearly half the nation's population at that time. The study noted that approximately 26 percent of American adults ages 18 years and older suffer from a diagnosable mental disorder in a given year. Comorbidity of chronic and mental health issues was particularly high for Parkinson's Disease (51 percent) and cancer (42 percent).³

Traditionally, primary care physicians would treat the physical illness but not conditions that may or may not be associated with the primary diagnosis. For example, a chronically ill patient may be depressed. Their primary care doctor might refer them to a mental health specialist, or might not. That disconnect may keep patients from getting mental health treatments they need. While behavioral health is a common example of this disconnect, uncoordinated care can keep every sort of patient from receiving the care he or she needs.

"Shared vision, collaboration, shared information and the infrastructure to manage it is critical," Goran said.

"Probably the most important part after culture and vision is that you have to have the right capabilities to actually manage patients across the continuum and manage quality and total cost of care for the best patient experience."

INTEGRATION THAT WORKS

Despite the challenges, several health systems are successfully integrating provider networks for better patient care and satisfaction. A notable health system in Seattle handpicks specialists who work individually with their own primary care physicians. "They're all working in the same culture, so you don't have to go to the trouble of selecting, credentialing, re-credentialing, and aligning incentives like you would in an open-panel system," Goran said.

What this health system does well, he added, is their providers all share the same vision and values in delivering quality patient care. The organization focuses on each transition point, from primary care to inpatient, outpatient—and everything in between. Managing care transitions, especially from higher to lower acuity, can make a huge difference in the cost and quality of services.

While the above model is fairly rare in health care, separate organizations can still develop a shared vision and culture that focuses on keeping patients well.

"We have learned over the years now to figure out how to get the most out of the current reimbursement system, which leads to duplicate tests and services—and fragmentation," Goran said. "We're trying to reverse that with value-based care where the focus is on the outcomes and cost. This means providing the right care, at the right place, at the right time and moving the patient to the next lower level of care as soon as possible. If you don't do transitions properly, the patient will bounce right back."

Preventing bounce-backs requires information sharing between primary care physicians and other specialists. That means accurate medical records, communication between physicians and care managers, among others. In the case of patients with behavioral or mental health needs, providers should make referrals to outpatient services and coordinate care going forward.

¹ Bureau of Clinician Recruitment and Service, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, HRSA Data Warehouse: Designated Health Professional Shortage Areas Statistics, as of April 28, 2014.

² Creswell, J., E.R. Costs for Mentally Ill Soar, and Hospitals Seek Better Way, The New York Times, Dec. 25, 2013 http://www.nytimes.com/2013/12/26/health/er-costs-for-mentally-ill-soar-and-hospitals-seek-better-way.html?_r=1



For health systems, that means understanding what specialties are most-needed and integrating them into the broader provider network, Goran said. A critical component to making such integration work is sharing information between all providers involved in the patient's care.

Goran pointed out that most provider organizations lack a common electronic medical record (EMR) or population health management (PHM) platform where data on patient diagnoses can be aggregated and used for broader population health management.

"You try to do a better job and get better outcomes. This is the nature of continuous quality improvement. You are always measuring to see how you're doing, sharing that information among the network, trying to identify best

practices, replicate them, disseminate them, and trying to weed out variations that are unnecessary," Goran said.

"A robust EMR or PHM platform with appropriate access for all caregivers is essential to make this happen."

As CMS and other payers continue to push the market more toward value, health systems can respond by developing more integrated, patient-centered provider networks. To succeed in this new venture, health systems and their provider networks must maintain a holistic perspective of patient needs. The ultimate benefit is that patients receive the highest quality care for whatever health issues they face now and minimize as much as possible the health risks they may face in the future.

BUILDING A BETTER NETWORK

Patient-centered, integrated provider networks are not quick-and-easy propositions. Providers must understand the dynamics of their markets and determine how fast they are moving toward value-based care. From there, a detailed evaluation of where they stand in the market—leader, fast follower, or wait-and-see player—will determine how quickly change can be made and how much it will cost.

Elena White, vice president, network management and payment innovation for Optum, recommends health system leadership consider the following when developing a patient-centered network:

- **Construct a multidisciplinary team.** The best networks bring together capabilities from across the health continuum, starting with primary care and then adding specialty care and ancillary services.
- **Put more focus on outpatient services.** Keeping patients out of hospitals reduces their risk of contracting other illnesses and provides more specialized care for the conditions they have. By reducing inpatient stays, providers lower their own risk, which can increase revenue.
- **Incentivize primary and specialty care.** While incentives for primary and specialty care are important, they shouldn't necessarily be the same. Consider incentives around the total cost of care for primary care and around episodic care for specialists.
- **Share clinical information.** Integrated, patient-centered networks require data and analytics. Multidisciplinary team members should have access to patient care data regardless of where service is provided.
- **Agree on quality metrics.** An integral part of sharing vision and values of a patient-centered network is aligning providers with quality measurements the overall health system wants to achieve. As quality becomes part of the reimbursement equation in both fee-for-value and fee-for-service contracts, patient-centered networks require a continuous focus on quality improvement, with best practices replicated and disseminated to the rest of the integrated network.



³ Mental Health and Chronic Diseases, National Center for Chronic Disease Prevention and Health Promotion Division of Population Health, Issue Brief No. 2, October 2012 <http://www.cdc.gov/nationalhealthyworksites/docs/Issue-Brief-No-2-Mental-Health-and-Chronic-Disease.pdf>



INTERPROFESSIONAL COLLABORATION

| The Impact on Eliminating Individual Silos
and Meeting Industry Goals



INDUSTRY CONVERSATIONS

Optum risk and quality experts recommend this article for its high-value content surrounding value-based business models.

At Seattle's Virginia Mason Medical Center, teamwork is the name of the game. Health care providers who'd rather call an audible and play by their own rules are in for a surprise. "Teamwork is one of our core values here, and has been since the beginning," says Charleen Tachibana, DNP, RN, FAAN, senior vice president for quality and safety and chief nursing officer at the medical center, which includes a 336-licensed-bed acute care facility that is part of the larger, nonprofit integrated health care system. "So the concept of forming teams and reforming teams and coming together and working together really becomes a way of being. If people want to work in silos here, that doesn't work very well; they're not very comfortable, and they aren't able to move agendas very quickly that way."

It may seem strange that functioning as part of a team would cause discomfort, but the traditional paradigm of the physician as the sole controlling practitioner persists.

"Many health care professionals come with a mental model around what they expect when they're working with other health care professionals," says Tachibana, who recalls a physician job candidate who declined a position after learning of Virginia Mason's emphasis on collaboration. "I just think that's reflective of the profession and how they're educated in silos."

But if provider organizations are to have success as health care emphasizes value-based payment models, quality metrics, and integrated care models, then team-based care and interprofessional collaboration need to be the rule rather than the exception. Groups such as the Institute of Medicine, the Institute for Healthcare Improvement, and the Robert Wood Johnson Foundation, are championing the cause.

"Interprofessional collaboration is when health professionals and others are able to work effectively together on a team, sharing responsibility, understanding and having respect for each other's roles and points of view, and working well together to accomplish a bigger goal in terms of better care for individuals and families," says Maryjoan Ladden, RN, PhD, FAAN, senior program officer at RWJF, which released the report *Lessons From the Field: Promising Interprofessional Collaboration Practices*. The report highlights health care organizations with strong IPC models, including Virginia Mason.

[READ MORE ►](#)

IPC is hardly a new concept—the IOM has called for its use since its 1972 report *Educating for the Health Team*—but it has not fully taken hold in the workplace or in health care education in large part because of traditional payment models.

“When you have a model where the physician is paid and it’s fee-for-service, the other professions are cost centers,” notes Barbara F. Brandt, PhD, director of the Minneapolis-based National Center for Interprofessional Practice and Education at the University of Minnesota, a nonprofit center dedicated to furthering interprofessional practice and education in health care and funded by the Health Services and Resources Administration of the U.S. Department of Health and Human Services, RWJF, the Josiah Macy Jr. Foundation, and the Gordon and Betty Moore Foundation.

That is changing, Brandt says. “There’s so much more emphasis on primary care [now], and so the changing incentive systems are really driving the need for teams.”

More and more, health care facility leadership is realizing that quality of care, and subsequent reimbursement, hinges on the team-based approach to care, says Ladden. “When you think about returning hospitalizations within 30 days and all of the things that you can be financially accountable for that you weren’t before, I think it has finally dawned on people that no one health profession or entity can really manage all of these issues alone and produce the financial outcomes and quality and safety outcomes alone,” she says.

At Virginia Mason, the team approach to care delivery has been a key part of improving clinical and financial outcomes alike, says Tachibana.

“I don’t think we could do what we’re doing without having interprofessional collaboration,” she says. “We couldn’t move our quality agenda the way we’re moving it; we couldn’t drop our costs of care and have the care coordination that we have if we couldn’t work together this way.”

Tachibana points to the organization’s initiative surrounding sepsis as one tangible example of how inter-professional collaboration can improve care. “Sepsis is our leading cause of death in the hospital, as it is in many hospitals across the country,” she says. “We have taken our hospitalist team and our inpatient nursing team and really looked at ways that we reduce the time it takes to deliver the sepsis bundle.”

Clinical recommendations from the Surviving Sepsis Campaign call for interventions to be started within three hours of the presentation of symptoms of sepsis. Virginia Mason completed bundled interventions in as low as 24 minutes thanks to the interprofessional problem solving, she says.

Working from interprofessionally developed protocols, nurses are able to implement the first three elements of the bundle prior to the patient being evaluated by a physician, who is required to implement the fourth component, delivery of an antibiotic. When it was identified that there was a delay in the administration of the antibiotic, team members in the pharmacy department stepped in to help address the bottleneck in care, which is how intervention time was dropped to minutes in some cases.

Virginia Mason implemented IPC by looking beyond the professions to the patient. The health system has worked to create a culture and structure that puts the patient first and models collaboration at the leadership level. In 2002, when the organization revamped its strategic plan, the patient was designated as the driving force behind its mission and vision.

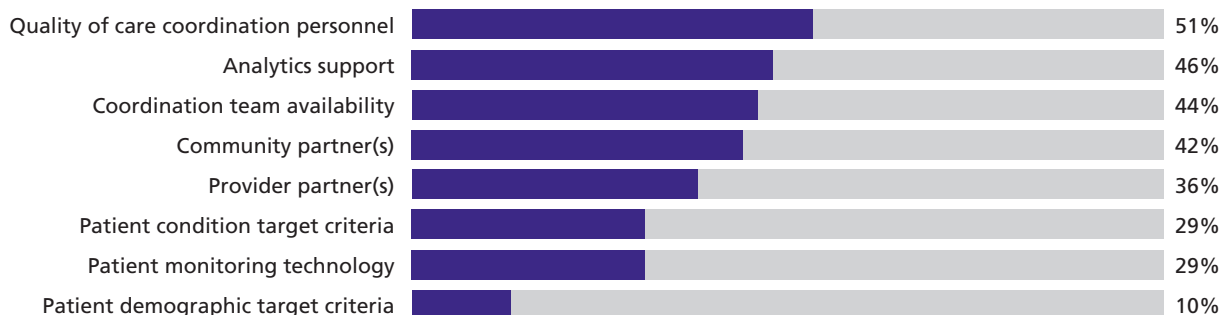
“Our true north is centered on the patient and improving our care and our processes and experience from the patient’s perspective,” she says. “If I’m working with a physician and I’m a nurse, it’s clear it’s not about me, it’s not about the doctor—it’s about the patient. The clarity of purpose and the clarity of intent and vision has been a key component as you bring a number of different professions together.”

Expectations for physicians, board members, the leadership team, and the organization itself are clearly outlined in Virginia Mason’s three compact documents, which detail the responsibilities of each group. For example, according to the leadership compact, the organization is expected to “offer opportunities for constructive open dialogue” and leadership members are expected to “continuously improve quality, safety, and compliance.”

“It holds us to our principles a little bit tighter and reminds us all of what we’re accountable for, and how we’re accountable to the organization,” Tachibana says of the compacts. “I think it reestablished those

CARE COLLABORATION IMPROVEMENT

Of the following care continuum coordination elements, which three are most in need of enhancement to improve clinical outcomes for your organization?



Multi-response

SOURCE: HealthLeaders Media Intelligence Report, Care Coordination: Closing the Gaps Along the Continuum, July 2015; hlm.tc/1KwLHwk.

norms and expectations about what teamwork is, and what it is to work together, and what respect looks like, and how we're going to focus on the patient."

Accountability is the key to making IPC part of the organizational culture, says Tachibana.

"If anybody is not willing to work collaboratively and respectfully with others, it's a problem and it's an unsafe situation," she says. "So, it's leaders being willing to do that hard work, to call it out, to coach it, to provide opportunity to improve, but, ultimately, if it doesn't improve, to say it's time to part." Tachibana adds, however, that it has gotten to that point rarely, not even once a year. "If there is an issue, leaders are expected to address it through training, coaching, referral to the employee assistance program, or through the use of other resources."

The health system also fosters IPC through its Virginia Mason Production System, its well-known management methodology based on Toyota's Lean principles. VMPS brings the various professions together during rapid process improvement workshops to improve care delivery processes.

Though collaboration is essential for health care systems in today's environment, interprofessional education is lagging, says Ladden.

"What we hear from the health systems is that new health professionals come into the health system very poorly prepared with how to work together because there hasn't been any interprofessional education or experiences at the entry level or the graduate level," says Ladden.

That's where the National Center for Interprofessional Practice and Education comes in, Brandt says. Her organization works with academic health care educators to develop team-based learning models that incorporate various disciplines and break down silos.

"We are charged with promoting teaching and learning of team-based skills and practice both in practice with the current practitioners and also with the pipeline, students that are in universities and the like," she says.

The center provides reports, training, and data for those interested in implementing IPE and IPC. Brandt says the center also is working to gather data on what types of teams are most effective in the new health care environment.

"As we go to value-based payments and we're redesigning health care, all those assumptions, we're throwing them out the window. So really understanding who's going to be on the team and what ways they're going to be working are all going to be called into question," she says.

Physicians, nurses, and other providers who have gotten used to working in silos will be forced to think differently, says Tachibana. "I think our patients will demand more collaboration and teamwork," she says. "It has to happen because the cost curve on health care has to shift; so we have to learn to work differently to optimize everybody's contributions here. The economics of [health care], if nothing else, will demand that we begin doing it differently."

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TRUST.

Contributed to *RISKMATTERS* by Joe Flower, Health Care Futurist and Speaker

THE SECRET SAUCE OF THE NEXT HEALTH CARE

The double doors to the ambulance bay slide open, and one more patient on a gurney is hauled across the threshold of your Emergency Department. They are in diabetic shock.

already lost money on the case. You were in essence paid to prevent it, and now all the costs of recovery are just plain costs.

"Volume to value," the shift from doing fee-for-service medicine to taking a financial risk in one way or another on the health of the populations you serve,

PARTNERS.

Stop the picture right there and ask yourself: Is this a medical success, because you can do something for this patient? Or a medical failure, because diabetic shock is entirely preventable and no one helped the patient prevent it?

That's the medical question. But you have to take one step further back to ask the question that will determine whether your organization thrives or dies over the next few years. The question is: Is this case a business asset? Or a business failure?

Under the classic fee-for-service arrangement, the case is a business asset. You can make money off that case. As long as they have insurance, or can be qualified for Medicaid, that person represents more volume. Under fee-for-service, the success equation is reimbursement per chargeable item times volume.

Under a shared-risk arrangement that person represents a business failure. The moment they show up you have

means a major shift in revenue streams, costs, and most importantly, partners.

How do you handle that? How do you survive in a world in which you are sharing risk? How do you survive by preventing the large acute cases that used to be your biggest sources of income? It's not easy, and it's probably impossible for you to do by yourself. You need partners, including partnerships that may be beyond the experience, training, and even comfort zone of many people who currently run health care organizations.

The technical parts are hard enough, such as what kind of corporate structures, joint ventures, revenue- and cost-sharing arrangements you should build, with what kind of risk structures and reinsurance schemes, as well as how you coordinate information structures across institutional lines. *That's hard enough. But however correctly you execute on the technical parts, none of it will work without the secret sauce: Trust.*

The secret sauce: trust

Maybe this sounds a little “Kumbayah” to you, a little soft and fuzzy. But in fact it is a hard functional reality that we need to get clear on for the life and future of your organization.

I’ll give you an example. Take a look at your computer. Look at its conceptual world: a virtual desktop with files in folders, a virtual trash can, a pointer. Most of that was invented by Xerox’s Palo Alto Research Center (Xerox PARC), with the mouse licensed by PARC from SRI (Stanford Research International) just down the road. So why aren’t we all working on Xerox computers? What happened? How did all that end up being the now-familiar world of Apple and Microsoft?

It’s a complicated story of not hitting the market right, wrong pricing, hardware and software really not ready for prime time, the usual. But when a later head of Xerox PARC asked the question, he pinpointed the key problem: Trust. The company marketing and strategy departments based in Rochester, New York, did not really understand the new desktop computer world. The sales team’s incentives were much better for their traditional copier products. The company’s own offices never used the new Xerox Star 8010 system or its successors like the 6085.

The real lines of trust ran socially between the engineers at Xerox PARC and those at SRI, and friends and acquaintances in the burgeoning personal computer industry, including famously Steve Jobs at Apple and Bill Gates at Microsoft. These people knew each other, understood the world the same way, talked the same language, and saw the enormous potential of using these

ideas for much better, faster, cheaper personal computers. (See John Seely Brown and Paul Duguid, *The Social Life of Information*.)


Lines of trust in an organization or across organizational lines are powerful efficiency engines, speeding information and plans and experience from one node to others who can actually put them into action, while impeding their transfer across gaps in your trust structure.

If you have ever tried to run a health care organization using the skills and creative effort of multiple different types of professionals, not just doctors and nurses, but interventional radiologists and physical therapists and pathologists and pediatric rheumatologists, you know it can be like herding bees—and just blaming them is no help. Cajoling, badgering, and trust exercises at weekend retreats won’t do it. Trust has to be built into the structure of the enterprise.



“  The lines of trust
efficiency in getting people

Risk is the reciprocal of trust



In the new “volume to value” world, the problem is magnified. If you take on a per-person per-month (PMPM) contract for managing the diabetes of a Medicaid population, or back pain for an employee population of warehouse workers, or whole lives under a fully capitated arrangement, you are no longer in the business of treating disease. Treating disease is only one of the tools for managing the patient’s health, and it is by far the most expensive way. What were revenue sources—procedures and surgeries and such—are now costs. So it is worth the life of your business to figure out whether they are avoidable costs. You are now in the business of managing the health of potential strangers, and you can’t do that by remote control. Can’t be done. Every method known requires not just the cooperation but the real bedrock trust of your patient population. And seamless coordinated care requires seamless lines of trust among all the clinicians involved.

Some 20 years ago Memorial Hospital in South Bend, Indiana, under the guidance of the great health care consultant Lee Kaiser, decided they needed to prepare for a future in which they would be at risk for the health of many people who were then uninsured. They decided to do this by simply giving them comprehensive health care. They would create special fully paid accounts for them under their captive insurance program, and just give away 400 family insurance cards within the community.

.....
They called Lee after trying this for a weekend.

“How many did you sign up?” he asked.

“None. Not one family. They didn’t believe us. There had to be a catch.”

“Wait a minute. Who did this? Who went door to door?”

“We did.”

“Really. A bunch of executives in suits from the big institution downtown came knocking on their door offering them expensive stuff for free? Why wouldn’t they believe you? Let’s figure out who they would actually trust.”

.....

Lee flew to South Bend. The hospital asked local pastors to come to a meeting and explained their problem to them. The pastors were happy to help. They went door to door and held events at their churches, and the 400 trial families were signed up in one weekend. The lines of trust were an engine of efficiency in getting people to work with them.

were an engine of
people to work with them.:

”

Who's on my side?

The best studies, clinical experience, and the record of such programs as Nurse Family Partnerships and the Iowa Chronic Care Consortium show that people trust someone:

- **Who they believe** is on their side
- **Who knows them** and has a relationship with them, or at least lives in their community
- **With the credentials** (such as an RN, an NP, or an MD after their name) to know what they are talking about

The Iowa Chronic Care Consortium, for instance, managed to lower diabetes events in the rural counties it covers by 6 percent, not huge but way better than the steady rise they had experienced before. Part of their successful formula was to reduce the number of patients managed by each care coordinator to only 250, half as many as in other programs, and to use diabetes education programs that already existed in the patients' own communities.

Similarly, when the Alaska Tribal Health Consortium and the native-owned Southcentral Foundation took their health care system over from the Indian Health Service, they redesigned every aspect of the system along the lines of tribal values, including working entirely in persistent teams, working with persistent panels of patients so that they built trusted relationships with them; rewarding the teams significantly for improving the health of their panels of patients; and shifting staffing so that most of the people the patients dealt with looked like them, talked like them and came from their community. The results were very significant improvements in health markers, including large drops in hospital admits, ED admits, pediatric asthma, diabetes, addictions, and many other major health problems of that population.

Nurse Family Partnerships have existed in a number of places across the country for decades, usually funded by state and local governments. Nurses in NFPs aggressively seek out young pregnant women in the community for special help and fundamental education.

How fundamental? One article about a similar program was headlined, "Don't put Mountain Dew in a baby bottle." Seriously, that was a prime instruction that many of these young mothers had never heard. A recent long-term study showed that, over time, such programs reduce abuse, neglect, poisonings and accidents by half—problems that would end up in the hospital emergency department as expensive cases. Counting those results as well as drops in arrests and other problems with both the children (up to age 18) and the mothers, the programs actually save governments considerable money. In fact, the return on investment (ROI) is 570 percent—every dollar a state or local government invests returns nearly \$6 in savings.

Despite this high ROI, Nurse Family Partnerships have continually struggled to find funding, because the expense is in today's budget, while the return is in the future and a benefit to someone else's budget. In the Next Health Care, in which health systems are often at risk for the health of populations, a smart health system would make a business out of it, finding a way to recoup some of that ROI through their risk-based contracts.

There are numerous papers and articles out there alleging that disease management doesn't work, population health management doesn't work, prevention programs don't work either to improve people's health or to lower costs. Look closely at the nature of the programs cited in those articles. What you will find is that they are programs that insert some third party into the equation, often someone in a call center reading from a script, or even a qualified nurse in person—but one who does not really know the community. These programs are searching for the less expensive, more "efficient" way to guide patients—but in the process they are short-circuiting trust.

Over time, the effort to short-circuit such trusted relationships has proven both expensive and fruitless. Real change in patient behavior happens only in the context of trusted relationships. The trusted pathway of the Next Health Care is not a simulation, it's the real thing. It's what you would want if someone were helping you.

“Real change in patient behavior happens

Divide and conquer

Effective population health management and prevention requires establishing trusted relationships with all of the population. Since people are in many different situations, this means you have to divide the market, and target strategies to specific parts of it.

The major divide is between strategies aimed at the whole community, and those aimed at “super users.”

Over any given period of time, over any given population, roughly half of all medical expenditures are generated by 5 percent of the people; 20 percent are generated by 1 percent. Who are these high spenders? Some are in a major health crisis. They have metastatic cancer, or they just got hit by a bus. Next year they will not be high spenders. They will be healed, or they will have lost the battle. Many of the high spenders, though, are in that category month after month, even year after year. They are typically people with multiple chronic conditions, poorly treated or untreated, that lead to multiple acute episodes.

Anyone who shows up in an Emergency Department 10 times in one year is a “super user.” The reason to identify them is that multiple pilot programs have shown that if you give them some serious medical help and hand-holding, you can drive down their acute episodes, help them manage their chronic conditions, make them healthier and happier—and save money at the same time. Boeing is the prime example, saving some 20 to 25 percent of the money usually spent on its top 5 percent “super users” by hooking them up with dedicated teams of clinicians. **If you are saving 25 percent on the 5 percent that generates 50 percent of the expenses, do the math: That means you are saving 12.5 percent on the entire population.**

There are actually many programs across the country that work like this that, either by design or as a consequence of the way the program sorts patients, end up bringing significantly more help to the least-connected, most-beset 5 percent, and through that saving money on the whole population.

Population management and “healthy communities” programs work with the whole population, but at far

lower cost. But here again, robo-calling, call centers and other disconnected attempts at connection don’t work: “Hi, I’m from an institution. I don’t know you, I don’t sound like you and I don’t live in your community—but let me tell you how you should change your life.” The secret sauce in programs that work is using trusted pathways to reach the least-connected populations, as we saw the Alaska Natives working with the tribal structure, and Methodist Le Bonheur Health System in Memphis allying with churches in a very church-oriented town. Other programs work through fraternal organizations, through neighborhood leaders, through employers, through unions or through neighborhood federally qualified community health clinics—any situation in which people know each other and can join with their neighbors.

Trust is fractal, it is self-similar at all scales, and so are its effects.

Take it granular. Promote “health posses.” Studies show a strong correlation between people’s health status and the number and strength of their connections with others. Navigating the health system and what you need to do for your own health is hard, and the more disconnected, disadvantaged and discombobulated by disease or addiction you are, the harder it is. Everyone should have one, two or a few people (spouse, friends, family) whom they trust intimately to help them through the process—look after each other, go to the doctor and pharmacist with them to ask questions and take notes, and to look for alternatives. This might be the biggest single change that you can help people with.

Trust is not a PR problem. It’s not a marketing problem. You cannot market trust into existence. If people’s experience of your organization is at odds with your marketing, your marketing will lose that fight, because people do talk about their experience vividly and with passion. You have to really be on their side, you have to mean it and you have to show it in their every experience of you.

Is trust expensive? In full-time equivalencies in this year’s budget, yes. But if you are at risk for the health of any population, it can more than pay for itself over time.

only in the context of trusted relationships.”

Within and across organizations

Of course, the Trust Algorithm does not operate solely in dealing with patients and patient populations. It also strongly enhances or impedes everything you are trying to do within the organization. Executives of health care organizations, if they have been paying attention, have learned this powerfully in all the consolidations and reorganizations of recent years. Many have not been paying attention, though. Buying up physician practices, then moving them around like Lego blocks to different parts of town, severing their existing patient relationships and forcing them to build new ones, is not the golden road to lowering costs and improving outcomes. Doesn't work. Nor is forming accountable care organizations or other alliances united by shared-risk contracts, without finding ways to bring the doctors together to create their own satisfactory work pathways, with IT that gives them the patient information they need from their colleagues, and with compensation that reflects their contribution to the whole process. The majority of all medical adverse events and malpractice cases arise out of poor communication

among clinicians. I have a number of times in different markets seen groups of physicians go "on strike" against other specialist groups with whom they have been lumped in ACOs, refusing to refer patients to them unless they learn to communicate fully, accurately and promptly.

This is the true secret sauce of organizations like Kaiser, Mayo, Geisinger, Scott & White and Intermountain: Most of the doctors work together regularly over time, often in the same building. They have a trust relationship.

You cannot simply assume trust between different groups of doctors. Distrust is the default. They have to actively build trust.

Trying to build a broad seamless organization without building trust, trying to cost-cut your way forward at the expense of trust, is simply bad management. In health care much more than other businesses, the mindset is thinking local, and trust is the glue and fuel of the organization.



Trust audit

Every organization needs to do a deep, careful Trust Audit. Study your organization and ask honestly what the experience of the process is for patients, different kinds of patients, patient families, employers, payers and the community at large, as well as for your physicians and nurses, and between your clinicians and those in organizations you are partnering with. Gather information by actually asking people what their experience is through focus groups, surveys and interviews. Find the gaps. Never tell yourself a story about why they should trust you.

That's a null story, and not helpful. Find out where they don't, and then explore in all seriousness how you can change that.

Trust is the hidden, undiscussed, most neglected engine of efficiency, lower cost and better outcomes in the new landscape of health care. Building real trust between real people is not the cheap way, but it is the effective way, and in the end the lower-cost way, to build the health care of the future.



Trust is fractal. It is self-similar at all scales and so are its effects.

Joe Flower is a speaker, consultant and futurist. He is a member of Speakers Express, author of *How To Get What We Pay For: A Handbook for the Healthcare Revolutionaries* and regular contributor to H&HN Daily.

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A silhouette of a person in a suit standing on a stationary bike, viewed from behind. The person is holding the handlebars. The background is a gradient from blue at the top to green at the bottom. The bike's frame and pedals are visible. The text 'TO HEALTH P' is overlaid in large white letters with a green shadow.

TO HEALTH P

LINKING PROVIDER-SPONSORED HEALTH PLANS TO VALUE-BASED TRANSITION STRATEGY

The health care industry is witnessing a rebirth of sorts as more health systems are creating provider-sponsored health plans (PSHP) as a way to increase revenue amidst decreasing inpatient volumes. In 2015, nearly a fourth of all health plans that entered the market were PSHPs. In total, more than 120 PSHPs exist covering approximately 30 million members (commercial, Medicare Advantage (MA), or Medicaid), or approximately 12 percent of all insured lives. By comparison, the top five U.S. health plans cover approximately 140 million people, or 4.5 times what PSHPs service.¹

LAN → OR NOT

But why would a provider organization want to run its own health plan? Twenty years ago, PSHPs were all the rage. A 1998 Family Practice Management article said that providers could cut out the “administrative/insurance middleman” by forming provider-sponsored organizations. By controlling all aspects of health care delivery, providers looked to reap millions of dollars in profits.²

They didn’t last. Capitation, a lack of operating and reserve capital, fierce competition from established insurance carriers and little understanding of actuarial and insurance risk forced most PSHPs of that time out of business.

“They simply didn’t have data available to determine what the risks were and how they needed to be managed,” said Erik Johnson, vice president, network and population health, for Optum. “There were no electronic health records (EHRs) and only rudimentary claims systems. On top of that, physicians and hospitals lacked experience in managing this type of business model.”

Two decades of technological advances and regulatory changes have set the stage for the PSHP comeback. With value-based models gaining traction, providers are preparing to assume more risk by emphasizing the continuum of care, Johnson said. Because health systems are on the front line, they are positioned to better understand what sort of benefits best suit their local communities.

However, that doesn't mean every health system is ready—or able—to launch its own sponsored plan.

RISK AND REWARD

Starting and running a provider-sponsored plan takes money. Lots of it. Not only do organizations need capital up front to acquire the staff and assets to build the plan, they must maintain strong cash reserves to sustain them through revenue downturns or when they must pay more than expected for their enrolled populations.

"In a growing start-up plan, for every dollar premium you bring in, you probably need 80 plus cents on the dollar sitting in the background to protect for unforeseen events," said Jay Hazelrigs, vice president ACO and provider risk advisory, for Optum. "So, it's a huge strain financially to build a growing insurance company. I think that some organizations underestimate that considerably."

The failure of PSHPs in the 1990s was due largely in part to capitation reimbursement that did not take into account the underlying risks providers assumed in managing their patients' total cost of care. Plans were using more services than could be supported by the capitated reimbursement from payers.

"Capitation was a bit of a blunt hammer in the 1990s. Provider plans were not able to manage the underlying medical expenses to the capitation payments," Hazelrigs said. Fast forward twenty plus years, providers do have more robust clinical and claims data housed in EHRs and financial analytic systems that can empower PSHPs to better manage risk and realize higher revenues.

"We're significantly further along in our abilities to manage risk than we were 20 years ago, but it's still not perfect," Hazelrigs said. "Success today in creating and maintaining a health plan—capital funding notwithstanding—requires several attributes."

First, and perhaps most important, is knowing your market.

CONQUERING BARRIERS TO SUCCESS

Provider-sponsored plans currently operate in 39 states, but there is remarkable variation in the number of plans in each state and the size of those plans. The 10 largest commercial plans cover nearly 18 million lives, or 43 percent of the overall market. The next 10-largest plans cover 20 percent, while the PSHPs account for only 1 percent.³

Understanding the competitive landscape and how to obtain market share is as much a necessity as having solid working and reserve capital, Hazelrigs said. "Are you competing with 10 health plans or only one? How big of a geographic footprint can you stake claim to, and what strengths do you have to potentially attract people away from competitors?"

Geography doesn't mean one big hospital, Johnson added. The right physician relationships define whether PSHP coverage is more than just a few blocks. In the end, it is about community presence and owning the health care continuum from one end to the other.

"Hospital markets are highly competitive. It helps to have market power and brand recognition in a particular region, especially when a few big health systems dominate a market," Johnson said. "Owning a good chunk of the patient continuum that goes beyond the four walls of the hospital is also important. Do you have good broker relationships? What about relationships at the state regulatory level?"

It also takes the right people to run a provider-sponsored plan. While providers are adept at managing patient care, PSHPs need to see far beyond office visits and hospital stays. It takes business operations' experts, marketing professionals, sales teams, and administrative wherewithal, Johnson said.

"Instead of just management of the patient, you have to do back office, middle office and front office. This means creating the product, selling it, building systems to pay providers and other functions around the management of finances," he said.

Success also lies in connecting with patients. Engaging individuals who will buy into and use PSHP services means more than sending forms during open enrollment. "Patients weren't as engaged 20 years ago as they are today," Johnson said. "There is more awareness at the patient level, and more tools for people to use, such as social media and apps, that drive transparency in costs, quality and health plan options."

MAKING THE LEAP TO A PSHP

As formidable as creating a PSHP may seem, some providers are actually well-positioned to take on a broader role.

“Providers have a sense of what the right benefit packages might entail,” Johnson said. “They may actually end up writing policies that are better tailored to their local communities.”

Before ever reaching that point, provider organization leadership must conduct a competitive analysis of both the hospital and payer markets. Hazelrigs recommends a

detailed assessment of your capabilities, which are then compared to what the market currently offers. This makes it easier to see what internal capabilities already exist for the PSHP and what ones need more development.

“Down the road, you’re going to discover you have some blind spots,” Hazelrigs said. “Going through strategic exercises about what you have to offer and what you need will allow for development of business case possibilities.”

A VIABLE PSHP BUSINESS CASE SHOULD EVALUATE:



The amount of capital needed to start and maintain the plan, with emphasis on capital reserves to weather hard times



Market competition and how a new PSHP can succeed through organic growth



Regulatory requirements in the chosen plan geography that will impact how the PSHP operates and what rules it must follow



The staff needed to operate a PSHP from end to end: clinicians, marketers, salespeople, actuaries, administrators, etc.



Data and analytics systems that provide a complete picture of the care continuum, population health, risk management, financial stability, etc.



Increasing patient, provider and employer engagement

Strategic analysis may point toward a provider-sponsored health plan, or it may not. Regardless, Hazelrigs and Johnson said providers must move toward some kind of value-based structure. CMS already is tying reimbursement to quality, and other payers are quickly following suit.


Johnson said providers “have to choose a lane at some point” when it comes to value-based care, and while

PSHPs are one option, there are many more ways that providers can reduce the total cost of care while improving margins. Providers need to take a more global look at cost. That means understanding market dynamics, internal strengths and weaknesses and how much capital the organization has to invest. Doing so will help providers make the most of fee-for-value reimbursement while maintaining the highest quality of care. **RM**

¹ 2015 AIS Health Plan Directory

² Stephen C. Gleason, DO, Jacque J. Sokolov, MD, and Christine Henshaw, MBA, Provider Sponsored Organizations: A Golden Opportunity in Medicare Managed Care, Family Practice Management, March 28, 1998 <http://www.aafp.org/fpm/1998/0300/p34.html>

³ The emerging story on new entrants to the individual health insurance exchanges, McKinsey on Health care, McKinsey & Company, September 2015 <http://health.care.mckinsey.com/emerging-story-new-entrants>

A portrait of Brian A. Nester, a middle-aged man with grey hair, wearing a dark pinstripe suit, a light blue shirt, and a patterned tie. He is smiling slightly and looking towards the camera. The background is a blurred indoor setting with large windows and some colorful, out-of-focus light streaks on the left side.

Brian A. Nester, DO, MS, MBA, CPE, FACOEP
President and CEO
Lehigh Valley Health Network

RELATIONSHIPS



Lehigh Valley Health Network (LVHN) built its first hospital in 1899 with the goal of elevating the health and well-being of its community. They wanted to pursue a new concept for how to approach health care with a core mission of improving care quality to achieve better outcomes. Over time, LVHN brought together a large network of member hospitals, physicians, and local organizations. This network was designed to provide access to quality care and promote wellness resources across their community. However, as they grew, they discovered it would take more than these adjustments to sustain their vision. They realized it would take new kinds of relationships and innovations to be able to continually respond to patient needs and meet ever-changing market demands. LVHN started with a small number of on-staff physicians, expanding from 100 physicians in their early years to over 700 today.

Currently, LVHN has five hospital campuses and 14 health centers with 95 clinical specialties, 17 primary and specialty clinics and more than 1,300 care providers. They have also been named a U.S. News & World Report Best Hospital nationally for the past 20 years. And they continue to pioneer new business processes and innovative ventures in a health care industry that is quickly shifting to value-based care.

SHIPS AS A STRATEGY FOR GROWTH

Foundational to their approach, Brian Nester, DO, MS, MBA, CPE, FACOEP, President and CEO of LVHN, believes that no doctor, hospital or insurance company can stand alone in value-based care. More than ever before, each element of the health care system holds a growing influence on how other parties perform. First and foremost, each organization must be strong, scalable and technologically savvy before they can find and add value to their partnerships.

Looking within the organization to evaluate and optimize business operations was a first step in beginning to increase quality and value. Better outcomes, financially and clinically speaking, have been the result of many internal and external parties working together. Let's start by taking a look at their core.

Rethinking internal relationships

LVHN recognized early on that many organizational concepts that held true for providers in the past needed to evolve. They saw that the ability to respond to new populations, evolving technology, and the industry's shift toward risk required large organizational adjustments to better empower and enable the constituents within their walls.

To do this, LVHN co-created the Lehigh Valley Physician Hospital Organization (LVPHO) to provide a strong conduit for communication. Physicians were able to create clearer pathways for shared data and information—giving each care provider extended capabilities to pinpoint and positively adjust their care decisions. A physician incentive structure was then developed to reward providers on participation and quality metrics. This allowed LVHN to migrate away from the fee-for-service model and compensate providers based on value—not volume. This early action proved that strengthening internal partnerships and their communication points could achieve the desired results.

LVHN's internal partnerships model has evolved into an established and well-integrated, yet constantly evolving, foundation for growth.

It now includes:



1. Technology teams

Through the creation of a wholly owned subsidiary, Populytics, Inc., LVHN has the capability to merge claims data with clinical data and provide timely, actionable information to its physicians. This information includes retrospective and prospective data for risk stratification of the population to streamline care across the continuum. Populytics combines industry expertise and data insights with its technology assets to identify strong opportunities for organizational growth, while supporting LVHN's goals to provide better health and better care at a better value.

3. Cohort of clinical leadership

The Population Health Management Executive Workgroup was formed across departments to evaluate data and provide actionable insights to clinicians to help ensure that LVHN achieves the clinical outcomes they expect. For example, this workgroup helps to facilitate a focused dialogue between analysts and physicians, supporting them with well-visualized integrated data so they can see exactly where they need to focus their efforts. This collaboration in combination with these tools makes the data more accessible, most relevant, and much easier to act upon.

2. Health plans

LVHN provides a self-funded health plan to their employees and dependents. In order to optimize outcomes, the health plan data is converted into insights using Populytics. Gregory Kile, President and CEO of Populytics, said, "as a result of the data, we have information that we can directly share with providers to assist them in providing timely, targeted care. These same insights allow for increased communication, transparency, and enable a more informed discussion between the patient and their physician. The result is a constantly improving cycle of growth and a better served employee population."

4. Internal educators

LVHN created Populytics Academy to educate all constituents within the network on population health and the value of predictive data analytics to drive interventions. Dr. Nina Taggart, Administrator, Population Health, Center for Connected Care and Innovation for LVHN, translated what this means. "Clinical and financial data are very powerful once combined. And because those data conversations have different meaning for the business folks than for the clinicians, we bring them together in Populytics Academy. It's helping us to get these teams to speak the same language and with shared understanding. We can already see its impact on our strategic planning process."

These partnerships, along with countless others inside of LVHN, contain a strong element of technology to gather and analyze data, which is then shared throughout the organization. It allows each partner to build insights, collaborative connections, and a culture of continual improvement and growth. Having a culture that values partnerships and information sharing allows LVHN to confidently merge with external communities and to approach acquisitions and unique partnerships with greater success.

Transforming relationships outside LVHN

LVHN recognizes that an “Us vs. Them” attitude doesn’t work in today’s value-based care environment. Because of the shift from volume to value and their established PHO, LVHN has transitioned to the “You and Me” collaborative approach to address the need to provide patients the best care at the highest value. And LVHN has employed technology to support the move across several categories.

Vendor partnership

By adopting a single electronic health records system, Dr. Nester explained, LVHN has been able to replace more than two-dozen individual systems. Working with their electronic medical record (EMR) vendor, they were also able to develop MyLVHN.com to allow patients to become more engaged in their own care with self-service tools. Additionally, the site offers great patient education modules to improve care and prescription requests to streamline basic care needs.

LVHN also pioneered the use of analytics, powered by Populytics, to further push toward value. Using the predictive capabilities of Optum One, LVHN has merged its clinical and claims data into a powerful analysis of its practices and costs. In a 12-month span LVHN identified six critical clinical initiatives that spotted high-risk patients, gaps in care and varied opportunities for improved value that were projected to save the health care organization \$3.1 million in a one-year period.

“This has taken us to a whole new level,” said Kile, who also serves as Senior Vice-President, Insurance and Payer Strategies, at LVHN. “The data, collaboration and tactics to achieve the savings have stimulated other efforts within the network.”

Student education

LVHN is a strong believer in both patient and clinician education and works with the University of South Florida to offer the SELECT program:

SELECT stands for Scholarly Excellence, Leadership Experiences and Collaborative Training. We are looking for students with the intellectual perspective, empathy, creativity and passion to change patient care, the health of communities and the medical profession.

Students will spend their first two years learning in a highly progressive, student-centered medical school, the USF Health Morsani College of Medicine in Tampa, Fla. They will then spend their final two years learning inside a

“As a result of the data, we have information that we can directly share with providers to assist them in providing timely, targeted care.”

Gregory G Kile

President & CEO
Populytics

Senior Vice President
Insurance and Payer Strategies
Lehigh Valley Health Network



technologically advanced health network—Lehigh Valley Health Network in Allentown, Pa.—that’s recognized nationally for quality, safety and collaborative care.

Provider networks

LVHN is a member of AllSpire Health Partners, an interstate alliance of seven health care systems. With AllSpire, Populytics stratified data from over 135,000 patients in order to identify gaps in care, high-risk populations and opportunities for cost reduction. As Kile explained, “The notion for us is to launch innovation that can expand throughout the AllSpire footprint.”

One of LVHN’s proudest achievements is a recently formed alliance with Memorial Sloan Kettering Cancer Center in New York City, the world’s oldest and largest cancer research and treatment center. Their goal is to begin a unique and forward-thinking collaboration aimed at improving patient access to the latest and most effective cancer treatment advances and highest-caliber cancer care.

Patient and community relationships

As the largest employer in Lehigh Valley, LVHN already has a presence that can touch many lives in the community. However, after running raw claims data there appeared to be a select group needing special attention. Within a population of 25,000 members, a mere 380 were driving the bulk of the costs. Placing a new focus on that 1.5 percent of their patient base, LVHN could proactively manage their care needs and significantly reduce costs.

Dr. Nester explained, “Many of these patients wanted help. We found that nearly a quarter of them didn’t have a primary care doctor, they weren’t a part of a care program, and they didn’t know who to talk to. Once they did, they were ready to get started.” Sameera Ahmed, senior health care analyst for Populytics, continued on this point, stating, “Predictive analytics, from Populytics, can also be a driving force behind the workflow of a

community care team [health care professionals who care for the highest risk patients and are imbedded in primary care practices]. We use the models to identify high-risk patients and help them to get the resources and care they need.”

LVHN is also building new provider partnerships to improve specific patient populations, such as, children. Currently they partner with the Allentown Children’s Health Improvement Program to help ensure children learn healthy habits at an early age.

Payers and employers

Over the last five years, stakeholders at LVHN have become very aligned in their attention to the financials, the analytics and what insurers and providers can do together to provide better care at a better value. Dr. Nester said, “If there is any tipping point that the Affordable Care Act precipitated, I think it was driving closer relationships with payers and providers.”

He also noted that fully-insured employers could be challenged as many of them hold their health care costs in the hands of external entities and review claims data only once or twice a year. They are not structured to quickly spot high-risk employees, recognize their engagement patterns, and support better coordination of their care.

“Supporting employees requires an integrated approach that includes providers, payers, care teams, and employers. Each of these stakeholders has a very different knowledge base, a specific point of view and a unique pressure, and we’ve needed to learn how to communicate effectively with each of them. We use our experience and assets to help align incentives and lower expenses, and good communication is critical to putting that knowledge into effect.”

The partnership end goal

"Partnerships are evolving," Kile explained.

"There's a good chance that what we're doing today within our partnerships and relationships likely will not look the same a year or two from now.

This transformation will be fluid and flexible and we will continue to create, amend, or potentially even end relationships in order to offer the patient greater transparency, care and affordability."

The evolution of our health care system can be challenging. However, as LVHN demonstrates, building relationships, sharing information to improve knowledge, learning to speak a common language, all while constantly adjusting as you learn, can position you for the true end goal: providing the best care, with the highest satisfaction at the best value.

Nina M. Taggart, MD
Administrator, Population
Health, Center for Connected
Care & Innovation
Lehigh Valley Health Network

Sameera Ahmed
Senior Health
Care Analyst
Populytics



A lasting partnership

LVHN partners with Optum to use the intelligent health platform, Optum One. LVHN through their Populytics business, is streamlining population health management and their value-based transition by converting health information into health intelligence. With access to several applications, LVHN is delivering point-of-care insights, driving effective, risk-driven care management and using an evolving cloud-based platform. LVHN is also partnering with OptumLabs to enable innovative and groundbreaking research designed to improve patient care and patient value.

The innovation happening at the Lehigh Valley Physician Hospital Organization is proving the combined value of connectivity, collaboration and communication. Their important work on creating broader relationships—past the common payer/provider interaction—is a new and effective strategy in shifting to a value-based environment. Mastering connections, sharing information in a smart, streamlined fashion and applying new learning to the workflow every day has given LVHN the ability to strengthen their foundation, stay responsive to an ever-changing industry and create new opportunities for growth in value-based care.



Matching your provider network to your value-based model and payer contracts

Creating a high-performing provider network starts with a vision.

A value-based strategy has many elements, one of which revolves around choosing the right care providers for your network.

Providers chosen for your network vary in performance and quality but must fit your long-term vision of your position on the risk continuum. Begin with the end in mind when choosing a high-performing, quality-minded network of professionals.

Use data and analytics to identify top-performing providers



FOCUS: Identify high-performing PCPs* and key specialists. Gather accurate patient data.



Quality of Outcomes



Cost Effectiveness

TYPE OF RISK



Service



Dollars

Fee for Service Plus Incentive Model

Ex. Patient-centered medical home

*PCP- Primary Care Provider

Share quality and cost benchmarks



FOCUS: Coordinate with a narrow group of specialists to address costly and undertreated disease states within your population.



★ Quality of Outcomes

🔄 Cost Effectiveness

TYPE OF RISK

| | | |
|-----------|----|---------|
| ★ Quality | + | Bonus |
| 🏆 Service | \$ | Dollars |

Upside Model

Ex. Medicare Shared Savings Track 1

Operationalize cost and quality reporting



FOCUS: Share performance metrics to scale models by disease. Reward quality outcomes and cost effectiveness.



★ Quality of Outcomes

🔄 Cost Effectiveness

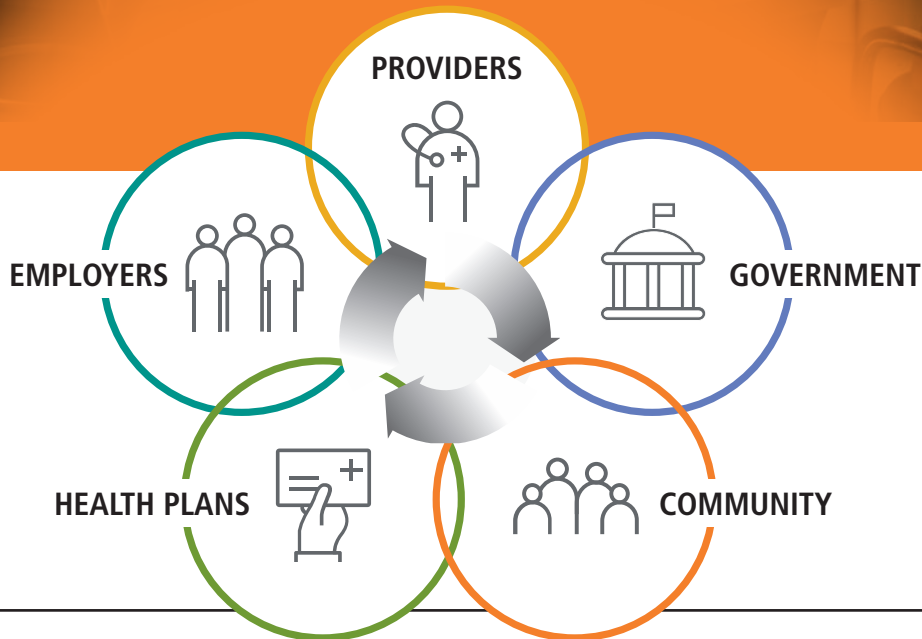
TYPE OF RISK

| | | |
|-------------------|----|---------------|
| ✂️ Cost Reduction | + | Bonus/Penalty |
| ★ Quality | - | |
| 🏆 Service | \$ | Dollars |

Upside/Downside and Capitation Models

Ex. Medicare Shared Savings Tracks 2 & 3

RESPOND TO RISK WITH THE RIGHT RELATIONSHIPS



Managing the transition to value-based models requires transformational leadership and a vibrant ecosystem. As your organization engages further with new business models, you may discover the power of evolving current and bridging new relationships to advance your mission.

At Optum, we believe partnership is paramount to innovation and growth. Through our *RISKMATTERS* publication and website we have gathered viewpoints on the future of health care from across the industry. Our goal is to help you build the partnerships that will bring insight, strength and stability where you need it most.

Explore more
on risk and
relationships at:

optum.com/riskmatters